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***Request for Contract  
Amendment Guidelines***

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***Date:***

***TO:***   
***LCMHB/Program Director***

***FAX: 419-244-4707***

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***FROM:***  
***AGENCY:***  
***PHONE:***  
***FAX:***

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***What type of amendment is being requested?***

***How much of an increase is being requested?***

***Reason for request? Provide explanation.***

***-Is the agency serving more clients? Adults? Kids?***

***-Is the agency providing more service to the same number of clients? Adults? Kids?***

***-Has the agency added direct/support staff?***

***-Has the agency implemented new programs?***

***-Did the mix between medicaid and non-medicaid change?***

***LCMHB Questions:***